DBHDS
Virginia Department of
Behavioral Health and
Developmental Services

# An Exploration of Mental Health Needs and Perceptions in Virginia's Refugee Population

*Office of Cultural and Linguistic Competence*

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## Purpose

In 2011, the Virginia Department of Social Services, Office of Newcomer Services (DSS-ONS), was awarded the Preventive Health Grant which aimed to make integrated preventive health, including mental health, an integral part of Virginia's comprehensive refugee resettlement model. As part of the grant, DSS-ONS contracted with the Virginia Department of Behavioral Health and Developmental Services (DBHDS) to conduct research specific to understanding the delivery of effective mental health services to refugees throughout the state. This contract resulted in the following needs assessment which explored the numerous barriers in accessing and achieving positive program outcomes for refugees receiving mental health services in Virginia. The following research is the first of its kind to formally address this issue in Virginia.

## Background

Since 1976, Virginia has resettled over 65,000 refugees, and currently ranks thirteenth in the number of new refugee arrivals and fourth in the number of affirmative asylees. Virginia's refugee communities exist throughout the entirety of the state, including Northern, Central Eastern, Valley, and Piedmont geographical areas. Virginia's refugees come from areas that include Africa (Burundi, Ethiopia, Liberia, Somalia, and Sudan), the Caribbean (Cuba and Haiti), Eastern Europe, the former Soviet Union, the Middle East (Afghanistan, Iran, and Iraq), and Southeast Asia (Bhutan, Burma, and Vietnam).

Refugees arriving in Virginia often have a host of medical problems, including mental health issues. DSS-ONS conducted an informal survey and found that refuges enter with many pre-existing health conditions, including mental health conditions such as anxiety, depression, post traumatic stress disorder (PTSD), and schizophrenia. Research has shown that refugees in general are at a higher risk for mental health issues due to common instances of exposure to violence in their home country, separation from family, and trauma before and during the process of immigration (Kaczorowski, 2011). Even upon arriving in the United States, refugees are at high risk for mental health problems. Language barriers, insufficient job skills, unemployment, living in low-income areas where crime and violence are more likely to occur, discrimination and prejudice, and acculturation stress are just a handful of the many stressors that refugees face upon entering the United States (Pumariega, 2005). Older refugee adults are at the highest risk for mental health problems due to the interaction of traditionalism and cultural inflexibility, linguistic barriers, lack of family and social support, and physical problems (Pumariega, 2005).

Unfortunately, it is difficult for mental health service providers to identify and treat refugees who are experiencing mental health issues. Cultural differences present a major barrier to treating mental health issues for this population. Refugees' concepts and beliefs regarding mental health issues may be embedded within spiritual or religious belief systems that do not align with the Western medical model used to treat mental illness in the United States. Additionally, health and mental health issues may not be immediately apparent following the chaos and excitement of the first days, weeks, and months after arriving in the United States. Although an individual may be experiencing mental health issues prior to their arrival, there is no formal screening process upon entry. These issues complicate the process of identifying refugees who are experiencing mental health issues and makes it less likely that an individual who needs services will receive them.

The consequences of not identifying and aiding those who need services can be high, particularly for this vulnerable population. Limited funding is available for refugees upon their arrival into the United States, and an emphasis is placed on employment in order for the individual to become self-sufficient. This creates an issue when mental health issues prevent an individual from becoming employed within the planned amount of time.

Anecdotally, Refugee Resettlement Agencies and others who work with refugees often struggle with how to help refugees who are identified as having mental health issues. Resettlement agencies are not designed to provide mental health services, and are often unsure where to refer an individual who requires services. There is currently no formal policy to aid resettlement agencies in connecting refugees to the public mental health system and ensuring that their specific language and cultural needs will be met. This study attempts to identify the major barriers to this population in an effort to provide guidance to stakeholders on how to improve services for refugees.

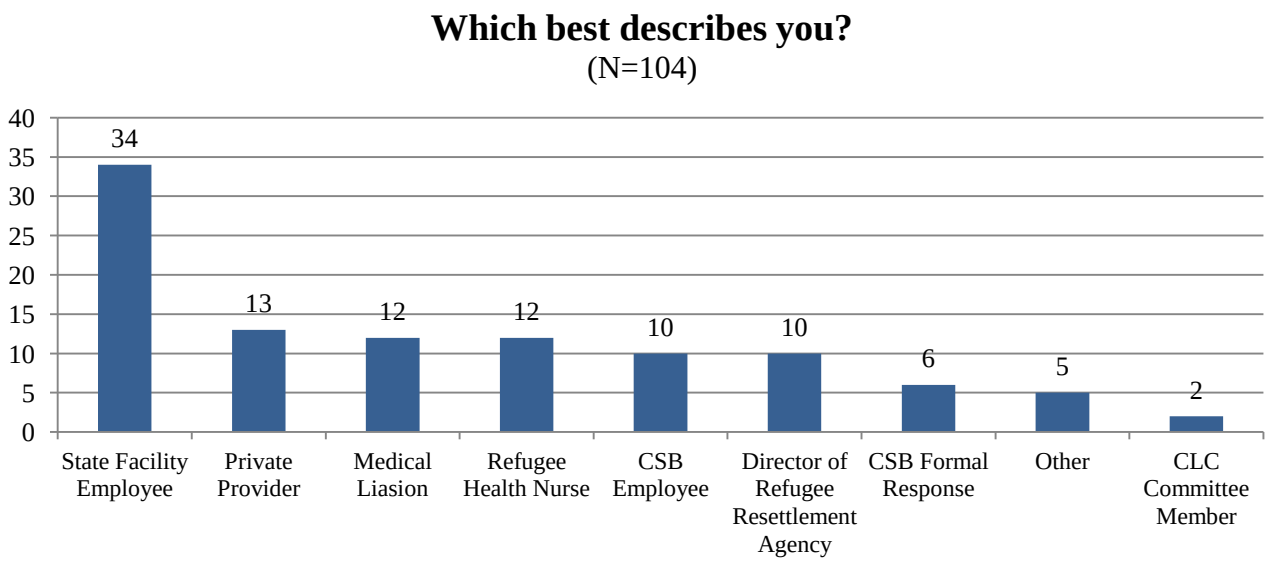
## Method

This needs assessment used two methodologies to gather data on the barriers for refugees in accessing mental health services. First, an online survey was created for service providers and distributed through various networks. The survey was also sent to 14 Community Service Boards (CSBs) whose catchment areas include the six general resettlement areas in the state, which covers approximately twenty-five of Virginia's cities and counties. A pilot survey was sent to five individuals representing various stakeholders, including CSBs, to receive feedback on the content validity of the survey. Each CSB was asked to complete one response in order to get the most complete understanding of the specific issues faced by that agency.

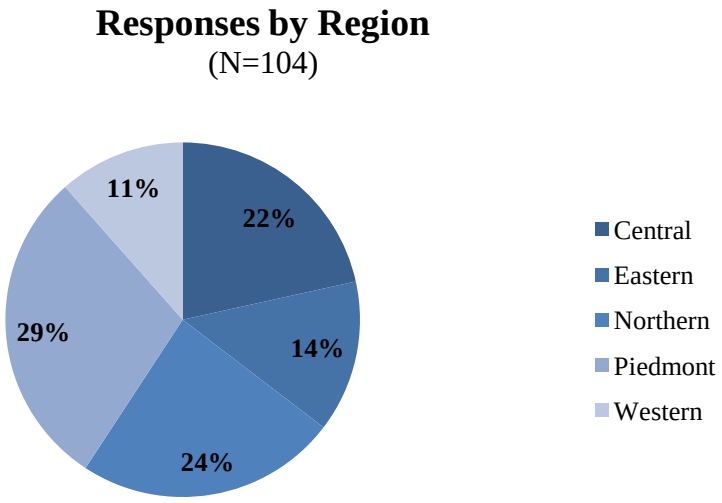
Key informants who have experience working with refugees and are knowledgeable about mental health issues impacting this population also provided information on this topic. Information gathered from these key informants will be included in the thematic analysis of the focus groups.

## Survey

Individuals who were known to work with refugees across all agency types were initially invited to take the survey. Further participants were suggested by the recruited individuals as well as by contacting other individuals identified through a search of other agencies in Virginia (snowball sampling). A total of ninety-eight individuals and six CSBs completed the survey. The following table shows a description of survey participants and how many of the participating agencies represented in the survey responses provide mental health services to refugees.




Respondents marked other include Social Services employee, refugee case manager, refugee education specialist, and administrative support. Of these participants, 64% report that their agency provides direct mental health services to refugees. Survey participants represented 52 of Virginia's 134 localities. The following pie chart shows the regional distribution of responses:




For a map of how these geographical boundaries are established, please see:
http://www.dss.virginia.gov/files/division/regional_offices/map_boundaries.pdf

## Results

The following results will be reported in order of the questions asked on the survey.

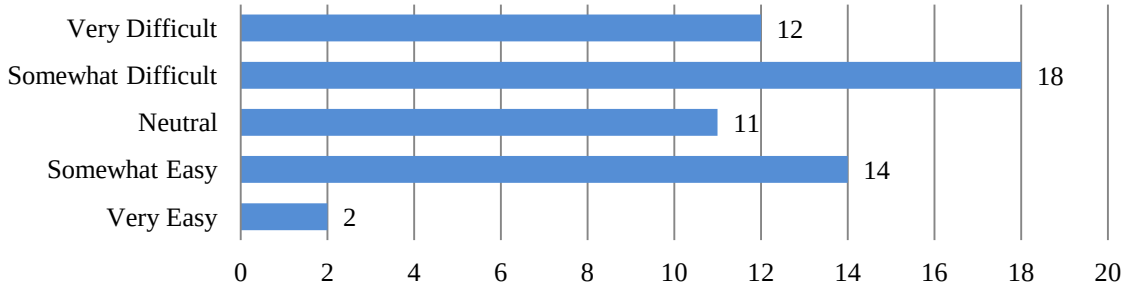
One important issue is how service providers identify that an individual is a refugee. This identification process is crucial as refugees will often require language services, special attention to past trauma and exposure to

violence, and other considerations unique to this population. The open-ended responses were analyzed for re-occurring themes across all responses. Major themes of how refugees are identified included:

- The individual self reports that they are a refugee
- Identification during the screening or intake process
- Agency has had contact from a refugee office or received a referral from a refugee office
- Documentation of refugee status (ex: I-94 Form, entry papers, passport)
- Refugees are not identified differently except for their need for interpreter services
- Agency has no formal system to identify refugees

Respondents were then asked to rank how easy or difficult it is for refugees to access services at their agency.

**On a scale of 1-5, 1 being "very easy" and 5 being "very difficult", how easy or difficult is it for a refugee to access mental health services in your agency?**
(N=57)




To expand on the results of this question, participants were asked to rank certain barriers in order of most difficult to least difficult. The barrier categories were established through a literature review on the most common types of barriers preventing access to mental health services for refugees.

**Please rank the following barriers to refugees seeking mental health services in order of MOST difficult (1) to LEAST difficult (4).**
(N=57)

| Rank | Barrier |
|---|---|
| 1 | **Language** (e.g. Interpretive Services) |
| 2 | **Systemic** (e.g. cultural issues, expenses related to mental health services) |
| 3 | **Cultural** (e.g. Attitudes toward mental health providers, stigma related to mental illness) |
| 4 | **Transportation** |

The results of this question show that participants view **language barriers** as the most difficult challenge facing refugees seeking mental health services, with systemic issues, such as insurance, and expenses related to mental

health services ranking second most difficult. Transportation was viewed as the least difficult barrier. In comparison to other survey respondents, CSBs ranked cultural barriers the second biggest barrier to refugees.

Participants were given a chance to write-in additional barriers not captured in these choices. Themes of additional barriers included:

- Access to mental health services is limited in a given area
- Refugees face higher isolation within their communities
- Ability to accurately identify mental health issues in refugees
- Complicated intake and screening processes that dissuade refugees from accessing services
- Perception that some individuals are not eligible for CSB services because they are not considered seriously mentally ill

Expanding on the previous question, participants were asked to rank the same barriers again, but this time to consider when a refugee is already in services.

**Once an individual is identified as a refugee and *is receiving services*, which of the following barriers MOST (1) prevents successful program outcomes?**
(N=57)

| Rank | Barrier |
|---|---|
| 1 | **Language** (e.g. Interpretive Services) |
| 2 | **Cultural** (e.g. Attitudes toward mental health providers, stigma related to mental illness) |
| 3 | **Systemic** (e.g. cultural issues, expenses related to mental health services) |
| 4 | **Transportation** |

Again, **language barriers** were ranked as the most difficult challenge which prevents successful program outcomes. Cultural barriers were ranked the second most difficult in helping refugees achieve positive program outcomes.

Respondents were also asked how many referrals to mental health services are made or received (based on being a service provider or working directly with refugees) per month. Of those who make referrals to mental health services, 52% report making 1-5 referrals per month. Of those who receive referrals, only 28% report receiving 1-5 referrals per month, while the majority report receiving no referrals. This data shows disconnect in how refugees are being identified and referred for services.

## Current Policies and Practices

Survey respondents were also asked to comment on current policies and practices aimed to reduce these barriers. Sixty percent of respondent's agencies currently have policies in place to reduce barriers to refugees seeking mental health services. Participants feel strongly that these types of policies and practices are important, with 47% of respondents ranking these policies as "very important" for their agency to implement.

Examples of policies currently in place to reduce barriers include:

- Providing interpreter services for clients or access to language line
- Bilingual staff
- Cultural competency task force established at CSB
- Documents written in other languages than English

While almost half of participants report it is "very important" to have policies in place to reduce barriers, only 37% say they feel their organization is "somewhat capable" to implement policies and practice to reduce barriers.

## Focus Groups

To further explore the barriers that refugees face, ten focus groups were held across the state in Newport News, Harrisonburg, and Richmond, Virginia. These focus groups included Arabic, Kurdish, Tigrinya, Spanish/Cuban, Sudanese, Eritreans, Burmese, and Nepalese nationalities. The focus groups were arranged by the local refugee resettlement agency to identify and recruit participants. Each participant was given an informed consent through an interpreter. The focus groups were semi-structured and covered the following main areas:

- What do members of your community do if their mental wellness is not good?
- What was it like for anyone in your community seeking help for mental wellness?
- How important is it to you to know how to get help for mental wellness?

The range of experiences for each group was varied. Some of the cultural groups did not feel comfortable speaking to this topic, while others were more willing to discuss issues around mental health. Only a few of the focus groups included individuals that had experience in the mental health system. As stated earlier, information gathered from individuals who work directly with refugees is included in this analysis to expand upon the barriers identified by refugees.

The following major themes reflect the barriers that refugees and other key informants who work directly with refugees perceive when attempting to access mental health services:

- **Cultural understandings of mental illness.** Many cultural groups stated that mental illness carries a stigma in their culture, and that individuals who experience this do not get formal help. Instead, family members and religious or spiritual figures in the community will assist that individual. Despite this, it was common for the groups to state that it is important to get help for serious mental health issues.
- **Knowledge of mental health services.** Due to cultural differences related to mental health, it was common for participants to come from countries without formal mental health services available. As such, some of the participants were unsure what constitutes a need for mental health services. When services are required, refugees are unsure how to access them or who to ask for assistance. Additionally, resettlement staff noted that there is limited awareness of the access method for mental health services in various localities. Similarly, they report frustration with wait times for services and availability of interpreter services.
- **Access to language services**. Some participants relayed experiences seeking formal help for mental health issues, but stated that inconsistent availability of interpreter services poses a challenge. Some

described the inability to communicate with a mental health professional during these times often makes the experience very stressful.

- **Transportation**. Many refugees stated that it is difficult to navigate the public transit system in their area, which makes scheduling and attending appointments more difficult.
- **Insurance**. A few groups cited lack of insurance as a reason that services are not accessed.
- **Normal immigration stressors versus mental illness.** Many of the focus groups cited mental health issues such as anxiety and depression within the context of immigrating to the United States. Many of these feelings are normal and to be expected when moving to a new country. There is difficulty in identifying an individual who may need professional help for mental health issues outside of these normal feelings. Many service providers cited this same issue and offered that education and awareness-raising about mental health issues may bring more people into services that need them.

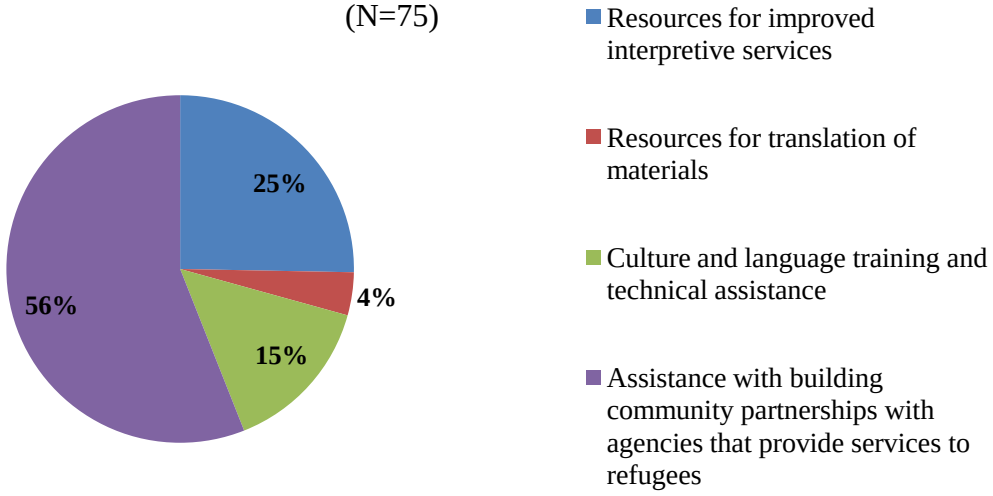
## Stakeholder Recommendations

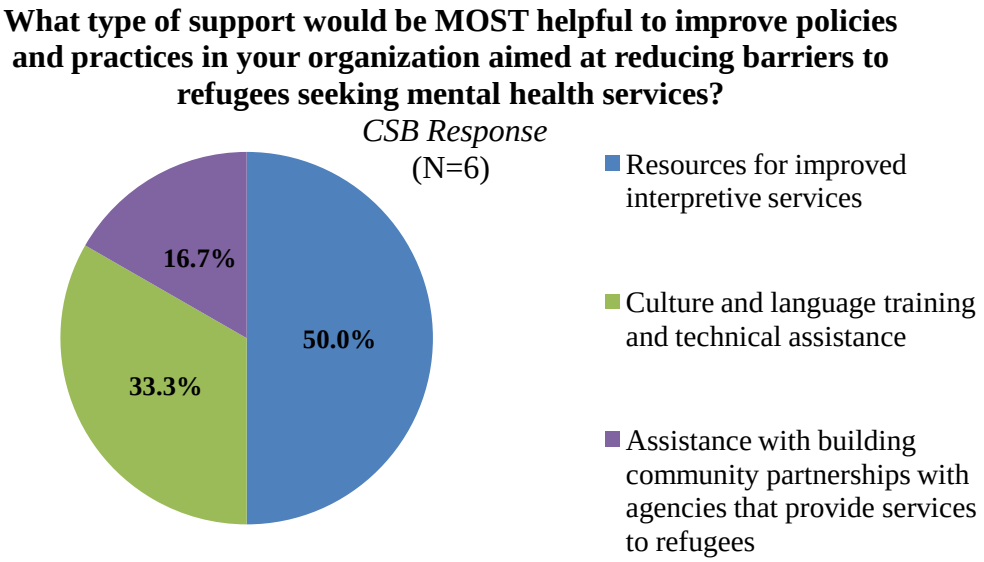
To better understand what policies may best improve services for this population, survey respondents were asked to rank the type of support that would be most helpful for reducing barriers.

**What type of support would be MOST helpful to improve policies and practices in your organization aimed at reducing barriers to refugees seeking mental health services?**

*General Response*

(N=75)






These responses demonstrate that there are different needs based on the type of agency. The following policy recommendations will provide ideas for policy makers at each level to address barriers for refugees who need mental health services.

## Study Recommendations

The recommendations below address three pressing issues identified in the research.

**Improving language services during the mental health encounter.** Language services were consistently ranked the largest barrier to services for this population. Funding is needed at the state level to ensure that the following policies can be implemented to assist CSBs in providing adequate language services.

- DBHDS and DSS-ONS should create a mental health interpreter curriculum for professional interpreters who are contracted to interpret in mental health settings. Particularly during mental health crises, many of the processes are complex and it is crucial that accurate interpreter services are available.
- Because language and culture are so intimately interconnected, local mental health agencies should be proactive in understanding the cultural nuances and traumatic experiences related to both refugees who currently reside in their communities as well as refugee groups that are slated to be resettled in their communities. This effort would include planning workforce development activities to increase awareness of refugee populations in the area, investing in outreach efforts to these populations, and assessing the need for cultural specific programming that would address the unique needs of this population.
- DBHDS and DSS-ONS should expand the Qualified Bilingual Staff Interpreter training to ensure bilingual staffs in resettlement agencies are proficient in mental health terminology to ensure effective communication when leveraging resettlement staff in mental health encounters.

- Private providers of mental health services should ensure that staff are trained in working with interpreters and the reasons why the provision of language services are important in service delivery.
- Funding support for interpreters during the initial phases of assessment and treatment for mental health entities who are developing formal partnerships with refugee services in their locality.

**Education for refugees about mental illness**. Results from the focus group show that cultural differences greatly limit the knowledge refugees arrive with about the Western perception of mental illness and when and how to seek help. Greater awareness and education around mental health may help prevent issues from going unnoticed and may promote communication between refugees and resettlement agencies related to such topics. Organizations could enhance services to refugees by developing the following policies and programs.

- **Peer Supports.** Resources should be allocated to build peer support networks among refugee populations in the Commonwealth. DBHDS should consider methods to fund non-traditional peer support programs at the local level. Local peer support organizations should evaluate whether there is a need to develop culturally specific peer programs in areas where refugees are resettled. Resettlement agencies should consider identifying members of a particular refugee community who are willing to become peer supporters for others in the community. Local mental health agencies who have peer support initiatives should consider incorporating culturally specific peer support programming into their annual plans. This may be especially important to consider in light of the fact that refugees are often more comfortable speaking to members of their own communities who share cultural beliefs and understandings of mental health issues. These individuals could serve as liaisons between the refugee community and the resettlement agency to bridge the cultural gap of understanding about mental health issues.
- **ESL Training in Mental Health**. Many ESL curriculums include health and wellness topics. Mental health should be included in these modules to educate refugee populations about this vocabulary. DSS-ONS, resettlement agencies, and adult education programs should support the formal integration of these modules into their existing curricula along with available resources in their communities.

**Formal policies to connect CBSs and resettlement agencies.** Results from research show that there is a lack of formal collaboration among refugee community stakeholders. This results in a failure to institutionalize cultural knowledge and agreed upon referral practices and protocols. Formalizing the partnerships between CSBs and resettlement agencies will allow for a smoother referral process when a refugee is identified as needing services. While there are many informal partnerships related to refugees currently in the CSB system, formal partnerships will institutionalize those connections. Formal policies will not only improve the referral process, but can also promote successful follow-through with services. The creation of a state-level interagency committee on refugee health and mental health may facilitate these collaborative efforts.

**Interpreter workforce development.** There is limited access to professional, trained interpreters, and all-too often family members or other community members must serve as interpreters. This often inhibits how much information is disclosed about sensitive issues, such as mental health. An interpreter workforce development program at the state level between the continuing education systems, DSS-ONS, and DBHDS would help

identify individuals who have the English proficiency to serve as interpreters and train these individuals to be able to work as professional interpreters. This would provide employment for refugees and a wider availability of languages that can be served by in-person language services.

**Mental health screening upon arrival.** Refugees receive a health screening through the Department of Health upon arrival in Virginia. This process currently does not include a mental health screening. A formal screening process would serve two functions- data would be available on the current need for mental health services upon arrival, and refugees who need services will be identified earlier. This screening process would only be successful if a formal process was developed between the local health department, the local community services board, and the local refugee resettlement agency that ensured a robust referral process was in place to address any concerns from the screening. DSS-ONS and DBHDS should commit to developing these partnerships moving forward, and consider ways to support this effort by funding a mechanism to facilitate these partnerships at a local level.

## Study Limitations

The results of this study must be considered within the context of some limitations. First, while all attempts were made to distribute the survey to all stakeholders across the state, some may have been missed. Similarly, focus groups were held in three major resettlement areas, but not in Northern Virginia, which has a large population of refugees. Finally, although professional interpreters were used for all focus groups, some of the concepts of mental health may not have been able to be translated accurately. Much of the data presented in this research warrant further consideration and study.

## Acknowledgements

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***For additional information, please contact:***

**Cecily Rodriguez**
Director, Office of Cultural and Linguistic Competence
P.O. Box 1797
Richmond, VA 23218
cecily.rodriguez@dbhds.virginia.gov

**Anne C. Cosby, MSW**
Refugee Mental Health Analyst
P.O. Box 1797
Richmond, VA 23218
anne.cosby@dbhds.virginia.gov

## Glossary of Terms

**Community Service Board (CSB):** A community services board is the point of entry into the publicly-funded system of services for mental health, intellectual disability, and substance abuse. There are 40 CSBs in Virginia.

**CLC Committee Member:** A member of the statewide Cultural and Linguistic Competence Steering Committee (CLCSC) which works with the DBHDS Office of Cultural and Linguistic Competence to enhance the ability of Virginia's behavioral health care system to effectively deliver linguistically appropriate and culturally competent health care to Virginia's populations.

**Department of Behavioral Health and Developmental Services (DBHDS):** DBHDS provides leadership and service to improve Virginia's system of quality treatment, habilitation, and prevention services for individuals and their families whose lives are affected by behavioral health disorders or developmental disabilities.

**Medical Liaison**: Five individuals located in the primary geographic resettlement areas who work to ensure refugee's medical needs are met by linking community health and mental health providers with resettlement staff and refugees.

**Office of Newcomer Services (ONS):** ONS is responsible for coordinating, planning, implementing and evaluating Virginia's refugee program. ONS administers a variety of federally funded programs which promote the earliest possible economic self-sufficiency and social integration for refugees into Virginia's communities.

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